Dental Health History

Name: _____ Date: _____

Please check Yes or No for those that apply to you.

Yes	No		Yes	No	
__	__	Bleeding, swollen, or irritated gums	__	__	Sensitivity to: Hot, Cold, Sweet
__	__	Clicking, Popping, or Soreness of jaw	__	__	Crooked or Tipped Teeth
__	__	Dry Mouth or Constantly Thirsty	__	__	Chipped/ Broken Teeth
__	__	Food catching between teeth	__	__	Clenching or Grinding
__	__	Smoke or Use Chewing Tobacco __ packs per day	__	__	Missing or Spaces Between Teeth
		Loose Teeth			Difficulty Opening or Chewing

Please check Yes or No if you have, or have had any of the following:

Yes	No		Yes	No	
__	__	Dentures or Partials	__	__	Veneers
__	__	Braces or Clear Braces (Invisalign)	__	__	Jaw Surgery
__	__	Periodontal Disease or Gum Treatments		__	__ Root Canals
__	__	Fixed Bridges	__	__	Sleep Apnea
__	__	Dental Implants		__	__ C-Pap Machine or Oral Sleep Appliance

If you could change my smile, I would:

__ Make my teeth whiter
__ Replace chipped teeth
__ Replace old crowns that look dark or don't match
__ Replace dark metal fillings with tooth-colored fillings
__ Fix my teeth so I'm not embarrassed when I smile
__ Close spaces or gaps that bother me
__ Replace missing teeth
__ Have a smile makeover
__ Help my jaw from hurting or clicking
__ Repair chipped teeth

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you?..... 1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?..... 1 2 3 4 5 6 7 8 9 10

	Yes	NO
Tell me about my options for replacing missing teeth with Dental Implants	__	__
Tell me how I can straighten my teeth if I'm a candidate	__	__
Have you ever been sedated for dental treatment?	__	__
Are you interested in sedation options?	__	__
Have you ever whitened your teeth?	__	__
Do you floss daily?	__	__

If this is your first time in our office, please answer the following:

Date of last cleaning __/__ Date of last oral cancer screening __/__ Date of last complete xrays __/__